



North Carolina's MFP Referral Form

Today's Date: _____

Participant Information					
Name:				SS # (last 4 digits):	XXX-XX-
DOB:		Medicaid #:		Medicare #:	
Is client financially eligible for CAP waiver services?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Street Address:					
City:		State:		Zip:	
Phone #:		Alternate Phone #:			

Contact and Agency Information					
Agency Contact:					
Email address:					
Street Address:					
City:		State:		Zip:	
Phone #:		Fax #:			

Responsible Party (i.e., Guardian)					
Name:					
Street Address:					
City:		State:		Zip:	
Phone #:		Alternate Phone #:			
Email address:					
Relationship to Client:					

Institution/Facility Information (where participant currently lives)					
Facility Name:					
Existing Funding Source:		<input type="checkbox"/> ICF/MR <input type="checkbox"/> ICF <input type="checkbox"/> Skilled Nursing			
Street Address:					
Mailing address, if different:					
City:		State:	NC	Zip:	
Contact Person's Name:					
Phone #:		Fax #:			
Email address:					
How long has participant lived here? (mm/yr - mm/yr)					

Preferred Living Arrangements		
Type	Check one	Comments
With relatives/caregiver in apartment		
With relatives/caregiver in home		
Alone in apartment		
Alone in own home		
In 4-bed or less group home (4 unrelated individuals)		

After completing this form and the MFP Informed Consent form, email or fax both forms to MFP staff at DMA Raleigh office: 919-733-2796. MFP Staff will notify the agency staff listed on the Referral form within 2 business days of the client MFP eligibility.

Important facts to remember:

- There is no CAP wait list for clients who are MFP eligible
- You must submit the MFP Informed Consent Form with this Referral Form
- Individuals in the following counties are **not eligible** for MFP - they continue with services under the managed care program: Cabarrus, Davidson, Rowan, Stanley, and Union
- There will be an additional page to complete if the client is given, and accepts, a waiver slot

MFP staff use only		
Eligibility Criteria	Check One	Comments
Meets qualified institution/facility	<input type="checkbox"/> Yes <input type="checkbox"/> No	
In institution/facility at least 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Meets qualified residence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicaid eligible	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Authorized by:			
Title:		Date:	